Legislative and Policy Analysis, Practice Guidelines and Related Publications within the Kenyan Context; Radical Abortion Care in a Pandemic, Briefing Report 2, May 2021

Radical Abortion Care in a Pandemic

Briefing Report 2, May 2021

Legislative and Policy Analysis, Practice Guidelines and Related Publications within the Kenyan Context

Authors: Phyllis Ndolo; Lilian Kivuti; Krestein Mwai; Brian Chiluba; Roy Lukama; Emma Campbell; Fiona Bloomer

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About the report: This report forms one of a series of outputs for the project Radical Abortion Care in a Pandemic (Kenya and Zambia). Other reports include: a review of the global context; a review of the Zambian context and an overall briefing paper. These can be accessed via https://pure.ulster.ac.uk/en/persons/fiona-bloomer/publications/

Section A - Background to the legal status and policy guidelines regarding abortion prior to the Pandemic

1. In Kenya the legal context regarding abortion is complex. A Kenyan girl or woman can receive 'post-abortion' care legally in all public health facilities, but she cannot get safe legal access to any abortion services whether in a public or private health facility. It has been a contentious issue that arouses public debate about morality in a mostly traditional and religious conservative African society.
2. For many years legislators and policy makers lacked the political goodwill to create a legal framework to domesticate updated WHO international guidelines and other related regional protocols regarding safe abortion as part of fundamental reproductive health rights. For instance, the East African Community Sexual and Reproductive Health Rights Bill of 2017, is a regional legal instrument that Kenya is obliged to adopt to improve the legal and policy situation of abortion in tandem to the Maputo Plan. However, Kenya still lacks an operational guideline in accordance with part III section 15 of the bill, which states that partner countries have a mandate to protect and facilitate a woman's reproductive rights by permitting abortion based on the recommendation of a trained medic (Federation of Women Lawyers, 2019)[1].
3. Coincidentally, Kenya in 2019 hosted the International Conference on Population and Development (ICPD), which came up with a document which was non-binding, commonly referred to as Nairobi Statement, that provides a global framework for the formulation of government and partner commitments. One of these promises was:

   > "Zero preventable maternal deaths through including access to safe abortion to the full extent of the law, measures for preventing and avoiding unsafe abortions, and for the provision of post-abortion care, into national Universal Health Coverage (UHC) strategies, policies and programs, and to protect and ensure all individuals' right to bodily integrity, autonomy and reproductive rights, and to provide access to essential services in support of these rights." (ICPD+25, 2019).

4. Prior to the new dawn of the new constitutional dispensation in 2010, abortion was a criminal offence and not considered a reproductive rights issue. This school of thought was anchored on the Penal Code, Laws of Kenya, Cap. 63, Revised Edition 2009 (2008)[2]. According to Article 158, a woman could be found guilty of a felony for attempting to procure an abortion and is liable to imprisonment for fourteen years. Article 159 states,

   > "Any woman who, being with child, with intent to procure her own miscarriage, unlawfully administers to herself any poison or other noxious thing, or uses any force of any kind, or uses any other means whatever, or permits any such thing or means to be administered or used to her, is guilty of a felony and is liable to imprisonment for seven years." (Federation of Women Lawyers, 2019)[3].

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[1] A review of 70 abortion related studies from 28 countries between 1994 and 2014 indicated that at least 9% of abortion-related hospital admissions had a near-miss event (complications which would have most likely resulted in death had the woman not made it to hospital) and approximately 1.5% ended up in death.

[2] The anti-abortion proposal is directly at odds with international human rights law and fails to recognise Kenyan women as full members of society with equal rights to life, health, equality, dignity and freedom from torture and cruel and inhumane or degrading treatment.

[3] Kenya's criminal ban on abortion bleeds through every area of the country's reproductive healthcare system," said Nancy Northup, president of the Center for Reproductive Rights. "Women can't get abortion services, including post-abortion care, when it's legal. When they do, the quality of care is

5. Article 160 specifically targeted any health provider whether professional or 'unlicensed' who supplied drugs including those used for medical abortion or instruments to procure abortion. If they were prosecuted using this article and proven guilty, they could face imprisonment for three years. Under the same penal code Article 228 targets late abortion of an advanced pregnancy. It states,

> "Any person who, when a woman is about to be delivered of a child, prevents the child from being born alive by any act or omission of such a nature that, if the child had been born alive and had then died, he would be deemed to have unlawfully killed the child, is guilty of a felony and is liable to imprisonment for life." (Center for Reproductive Rights, 2019)[4]

6. The penal code can be traced back to colonial influence, specifically the British 1861 Offences Against the Person Act. A paradigm shift to considering some exceptions of treating safe abortion not as a felony but part and parcel of reproductive health occurred in the context of significant advocacy and lobbying having previously failed, such as attempts to amend the penal code through a more progressive private member sponsored abortion bill in 2004. Eventually a more modern sexual reproductive health (SRH) friendly law embedding safe abortion was formally included in the new Kenyan constitution. The right of every Kenyan citizen to have access to quality sexual reproductive health services is now enshrined under Article 43(1)(a) which states the right of "Every person to the highest attainable standard of health, which includes the right to health care services, including reproductive healthcare". Shortly after its official promulgation, it turned out that it was one step forward and two steps back with regard to access to safe abortion services and information.
7. In September 2012, the Ministry of Medical Services published the "Standards and Guidelines for Reducing Morbidity and Mortality from Unsafe Abortion in Kenya." However, In December 2013, the Director of Medical Services withdrew the Standards and Guidelines without explanation, and without the involvement of the stakeholders who had participated in its development. The withdrawal was followed by a memo in February 2014 that further stated that there was no need for the training of health workers on safe abortion care or the use of the drug Medabon for medical abortion. The Ministry threatened health providers with dire legal and professional consequences if they participated in any abortion training.
8. Cumulatively, these actions created confusion among health providers as to when to offer abortion services, including post-abortion care services. The result has been a chilling effect: fearing reprisal, health professionals have opted out of providing services to women and girls even when they fall under the permitted legal grounds for abortion. (Center for Reproductive Rights, 2019)[5].
9. The Reproductive Health Care Bill of 2014 comprehensively revisited the legal challenges facing Kenya in reproductive health services, and in this case with a bias on legal abortion. Section 19 (1) of Part V titled "Termination of the Pregnancy" provides that a pregnancy can be terminated when a health practitioner with requisite training recommends that the pregnancy would endanger the health and the life of the mother.

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substandard at its best, deadly at its worst. And medical providers who do offer legal abortion services are either harassed or turn corrupt and mistreat their patients."

[4] Kenya already has one of the most restrictive abortion laws in the world. Under the law, women and doctors face imprisonment.

[5] Healthcare workers were prohibited from receiving training for, and offering abortion care. This meant that women and girls such as JMM seeking to terminate pregnancies that should have been allowed under the law resorted to unsafe abortions, with disastrous results.

Section 19 (2) directs that the procedure should only take place with the mother's consent or after consultation with parents of a minor, and the same case applies for a person who is mentally unstable. Despite all these laws and bills in the country, the unlawfulness and unclear provision of what actually constitutes lawful abortion in Kenya remained a major legal debate. (Federation of Women Lawyers, 2019)[6]

10. On 23rd May 2016, the publication of proceedings of Community and Policy Dialogue on Unsafe Abortion in Kenya which drew participants from medical practitioners, experts in the reproductive health, legal practitioners, government agencies and victims of unsafe abortion, recommended the following: revisiting, enacting and formulating of laws and guidelines including international ones such as Maputo Protocol's reservations on Article 14(2)(C), to provide and support availability and accessibility of safe abortion services as permitted by the constitution without discrimination, victimisation or stigmatisation of those seeking the services. It also suggested a review of various policies and laws that prohibit abortion by Parliament to give way to the development of a safe abortion delivery framework.
11. In addition, it urged the Government to provide a policy that increased budgetary funding for supporting safe abortion among other associated services such as comprehensive sexuality education. It concluded that the lack of supportive legal structures in this area has been associated with the increasing cases of unsafe procurement of abortion services from backstreet doctors. (Federation of Women Lawyers, 2019)[7]
12. The Health Act 2017, Section 6(1) is instructive on abortion matters as it provides: Every person has a right to reproductive health care which includes (c) access to treatment by a trained health professional for conditions occurring during pregnancy including abnormal pregnancy conditions, such as ectopic, abdominal and molar pregnancy, or any medical condition exacerbated by the pregnancy to such an extent that the life or health of the mother is threatened. Section 6(2) thereafter defines "a trained health professional" to refer to a health professional with formal medical training at the proficiency level of a medical officer, a nurse, midwife, or a clinical officer who has been educated and trained to proficiency in the skills needed to manage pregnancy-related complications in women, and who has a valid license from the recognised regulatory authorities to carry out that procedure. The Act also demands that any procedure carried out shall be performed in a legally recognised health facility with an enabling environment consisting of the minimum human resources, infrastructure, commodities and supplies for the facility (Griffith, 2019)[8].
13. Additionally, the Health Act and the Penal Code enables trained healthcare professionals to procure an abortion either in good faith or with reasonable care and

[6] The criminalisation of abortion in Kenya, combined with the stigma and shortage of legal post-abortion care, leads to the deaths of hundreds or possibly thousands of women each year due to complications of unsafe abortions, the New York-based Center for Reproductive Rights said in a report this month.
'These deaths are a direct consequence of Kenya's abortion law, one of the most restrictive in the world,' the report's authors wrote.

[7] Unsafe abortion in Kenya is among the highest in Africa. Maternal mortality is high at about 6,000 deaths per year, 17% of them from complications of unsafe abortion. Most women who go to hospital after unsafe abortion have moderate or severe complications, requiring specialised treatment and having lasting health effects.

[8] A person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation upon any person for his benefit, or upon an unborn child for the preservation of the mother's life, if the performance of the operation is reasonable, having regard to the patient's state at the time and to all the circumstances of the case.

skill if in their professional opinion the life and health of the person seeking abortion care is being threatened. Lastly, there are national guidelines on the management of sexual violence in Kenya which entitle victims of sexual violence to terminate a pregnancy. Outside these circumstances, the Penal Code criminalises 'unlawful abortions', creating an offence for both women who seek the services and persons that provide the services (Privacy International's Global Research, 2020).

14. Despite all the existing legal laws including the Constitution, amendments and policy briefs mentioned earlier, it took a ruling in 2019 High Court of Kenya Constitutional and Human Rights Division to enforce Kenya's obligation to provide legal abortion services. A background to this case has been provided and a demonstrated link to radical abortion care during the pandemic will be elaborated on later.

FIDA Kenya & 3 others vs. Attorney general & 2 others Constitutional petition no 266 of 2015

15. JMM, a schoolgirl from a poor family in rural Kisii, was born in 2000. Her mother, PKM, is a casual labourer, earning about Kshs. 100 (approx. USD 1) a day. When JMM was 14 years old, she was sexually assaulted by an older man. She suspected that she could be pregnant after two months when she started feeling nauseous. As is the case with many rape survivors, JMM did not receive information on post rape care that she was entitled to as a rape survivor. Aware of the stigma placed on rape survivors and fearing that she would be held responsible and rejected by society, she turned to the only person she thought would help her without judging her – an older girl with whom she shared a bedroom (Rights, Rights, Kenya, 19, & Worldwide, 2020)[9].
16. The girl introduced her to an unqualified provider who helped her procure an unsafe abortion. After the procedure, JMM was advised to go home and wait for the completion of the abortion process. At home, she began vomiting and bleeding heavily. She was taken to a nearby dispensary that was not well equipped and that lacked skilled staff. After a few hours, JMM was transferred to Kisii County Referral Hospital, the highest-level public facility in that county, located about 15.6 Km away from her home. She stayed at the hospital for three nights and received some treatment. The hospital established that JMM needed specialised treatment, a service they could not provide. She was therefore referred to Tenwek Mission Hospital for dialysis, a hospital of a lower classification, located about 50 Kms away. At Tenwek, JMM was immediately admitted to the Intensive Care Unit. By this time, she could not talk. She was discharged from Tenwek after seven days without adequate treatment on grounds that the hospital did not have a dialysis machine and could therefore not provide the services for which she had been referred and admitted for (Rights, Rights, Kenya, 19, & Worldwide, 2020)[10].
17. Twelve days after the unsafe abortion, JMM arrived at Kenyatta National Hospital – (KNH) the biggest referral hospital in the country – where she received the post abortion

[9] Abortion in Kenya reflected the reality that there was a high incidence of sexual violence against poor women and girls. JMM was such a child, and her ordeal presented a classic case of a failed health care system lacking in both skilled staff, facilities and a proper referral system. Her situation showed the dire need for training in the skills and knowledge needed to address the rate of deaths following unsafe abortions.

[10] The death rate from unsafe abortion is "disproportionately high" compared with other east African countries, it found. Esther Passaris, a Nairobi MP, wants the government to go further, and legalise abortion on demand. "Women and girls have the right to make decisions about their bodies," she said. "[And] whether we legalise it or not, it's happening."

care and dialysis. KNH diagnosis indicated that she had a septic abortion, haemorrhagic shock and had developed chronic kidney disease. About 68 days later, she was discharged but was detained at the facility as she was unable to pay for the hospital bill that had risen to Kshs. 39,500 (approximately USD 395). Consequently, she slept on a mattress on the floor at a "detention centre" in the hospital. She fell sick again and was taken to the main hospital for treatment for four days and later returned to "detention" for a further two weeks before her bill was finally waived when the hospital established, she could not pay. JMM lived with kidney disease arising from the unsafe abortion for three years and required dialysis every month. She passed away in June 2018 due to complications from the kidney disease (Rights, Rights, Kenya, 19, & Worldwide, 2020).

18. Her mother PKM, blames her daughter's predicament on the respondents. She argued that the Government of Kenya, through the Ministry of Health National Guidelines on the Management of Sexual Violence in Kenya, 2nd Edition, 2009 (2009 National Guidelines), made pursuant to section 35 (3) of the Sexual Offences Act, allowed termination of pregnancy as an option in case of pregnancy occurring as a result of rape. It was her case, further, that it is not clear how such services would be accessed. She contends that the physical and mental health of many women and adolescent girls would be protected if information was available with regard to the cadre of health professional that can provide services for legal termination of pregnancy (Federation of Women Lawyers (Fida – Kenya) & 3 others v Attorney General & 2 others; East Africa Center for Law & Justice & 6 others (Interested Party) & Women's Link Worldwide & 2 others (Amicus Curiae) [2019] eKLR, 2019).
19. PKM further argued that the withdrawal by the 3rd respondent the director of medical services of the 2012 Standards and Guidelines for Reducing Morbidity and Mortality from Unsafe Abortion in Kenya (2012 Standards and Guidelines), and the National Training Curriculum for the Management of Unintended, Risky and Unplanned Pregnancies (the Training Curriculum) on 3rd December, 2013 and 24th February 2014 respectively undermines the right to access safe legal abortion services, therefore leading to women and girls in the position of JMM to secure unsafe abortions from unqualified and untrained persons such as the 'doctor' who procured her abortion on 8th December 2014.
20. PKM's position was supported by the 3rd and 4th petitioners., Ruth Mumbi Meshack and Victoria Otieno Awuor respectively. These petitioners are both community human rights mobilisers residing in Mathare Constituency within Nairobi County. Their area of residence is a mainly informal settlement inhabited by persons of low economic status. They narrate in their affidavits in support of the petition their experiences with cases touching on women and girls' reproductive health, such as early pregnancies, defilement, rape, and unsafe abortion (Federation of Women Lawyers (Fida – Kenya) & 3 others v Attorney General & 2 others; East Africa Center for Law & Justice & 6 others (Interested Party) & Women's Link Worldwide & 2 others (Amicus Curiae) [2019] eKLR, 2019).
21. They noted that a number of young women and girls have been left with disabilities as a result of unsafe abortion. Some of them have died after undergoing unsafe abortions at the hands of unskilled persons within the Mathare community who claim to have the skills and training to undertake abortions. The 3rd and 4th petitioners contend that women and girls in their community choose unsafe methods to terminate their pregnancies due to inability to access trained health workers, sometimes due to lack of information about when abortion is allowed, and sometimes out of fear that the cost of

seeking legal abortion services may be beyond their economic means. The 3rd and 4th petitioners' support for the petition is based on their belief that there is need for the government to provide information to the public on the circumstances in which abortion is allowed in Kenya and who can offer legal abortion services (Federation of Women Lawyers (Fida – Kenya) & 3 others v Attorney General & 2 others; East Africa Center for Law & Justice & 6 others (Interested Party) & Women's Link Worldwide & 2 others (Amicus Curiae) [2019] eKLR, 2019).

Section B - Legal interpretation and practical application of relevant guidelines adopted by Kenyan practitioners during the pandemic based on the ruling of Constitutional petition no 266 of 2015

22. Kenya's High Court landmark ruling in June 2019 in regard to access to safe abortion in a case against Ministry of Health has set the legal benchmark that has been used and is still relevant during and post COVID-19 pandemic by safe abortion activists and stakeholders.
23. The Court found that the Director of Medical Services and the Ministry of Health had violated the rights of Kenyan women and girls by arbitrarily withdrawing the guidelines, thereby creating uncertainty as to the status of legal abortion and discouraging medical providers from performing abortions for fear of criminal prosecution (Rights, Rights, Kenya, 19, & Worldwide, 2020)[11].
24. It provided a comprehensive ruling that the blanket prohibition of abortion under the Penal Code cannot stand because it is inconsistent with the provisions of the Constitution as well as the Sexual Offences Act. Kenya's refusal to be bound by Article 14 (2) (c) of the Maputo Protocol to the African Charter on Human and People's Rights has no effect to the extent that those provisions of the Protocol mirror those in Article 26 (4) of the Constitution of Kenya, which is binding. Trained health professionals permitted by the Constitution to make an opinion that an abortion is necessary include nurses, clinical officers and midwives in addition to doctors and specialist obstetrician gynaecologists. The court agreed with and adopted the World Health Organisation's definition of health to mean "a state of complete physical, mental and social well-being, and not only the absence of disease or infirmity" (Center for Reproductive Rights, 2019).
25. The Court made the following orders:

> That by withdrawing the Standards and Guidelines and the training curriculum and by banning the use of Medabon, the MOH violated and or threatened the right of women and adolescent girls of reproductive age to: the highest attainable standard of health, right to non-discrimination, right to information, consumer rights, and right to benefit from scientific progress;
> That by banning the training of health professionals and use of Medabon, the MOH violated and/ or threatened the rights of health care professionals to information, freedom of expression and association, consumer rights, and right to benefit from scientific progress;
> That the acts of withdrawing the Standards and Guidelines and National Training Curriculum, the banning of training and use of Medabon were unlawful, illegal, arbitrary, unconstitutional, and were therefore void;
> That abortion is allowed in cases of emergency, to save the life or health of pregnant women, and as provided by any other written law. Abortion is also allowed in cases of rape or defilement if in the opinion of a trained health professional the pregnancy poses a danger to the life or the health of the mother (Federation of Women Lawyers (Fida – Kenya) & 3 others v Attorney General &

[11] Safe abortion is one of the main causes of maternal deaths in Kenya. Despite the fact that these deaths are preventable, seven women and girls die from unsafe abortion every day. Women and girls seek unsafe clandestine abortions due to a lack of access to reproductive health information and quality services, lack of clarity on the legal status of abortion, and pervasive cultural stigma.

2 others; East Africa Center for Law & Justice & 6 others (Interested Party) & Women's Link Worldwide & 2 others (Amicus Curiae) [2019] eKLR, 2019).

26. The High Court ruling has specific practical legal and professional implications for Health Service providers. The law on abortion and provision of abortion services has been clarified and there should be no confusion, distortion and stigma premised on the incorrect notion that abortion is totally illegal in Kenya. Ideally, legal abortion as a reproductive health service should now be available and accessible in all public health facilities across the country (Rights, Rights, Kenya, 19, & Worldwide, 2020)[12]. The Standards and Guidelines and the National Training Curriculum have been reinstated. The Court paved way for continued use of the two documents to care for patients and training of health workers. Reproductive Health Network Kenya since January 2021 has resumed Trainings of health professionals on provision of safe and legal abortion services.

27. The 5-judge bench's unanimous decision clarified actions and omissions criminalised in sections 158 and 159 and 160 of the Penal Code and actions permitted under Article 26(4) of the Constitution of Kenya. Constant harassment by police based on reliance of section 158-160 of the penal code without due regard to article 26(4) of the Constitution ideally should have ceased with immediate effect. Public prosecutors and courts should henceforth read the Penal Code sections 158, 159 and 160 with the necessary alterations, adaptations, qualifications and exceptions to bring it into conformity with the Constitution. They must ensure that doctors, nurses, midwives and clinical officers who provide safe and legal abortion services to women and girls are not harassed. The leadership of the police service should immediately commence sensitisation of police officers on the law regulating access to abortion services in Kenya to ensure clarification of values and destigmatise the police service (Centre For Reproductive Rights, Physicians For Human Rights, FIDA Kenya, Article 19, & Women's link Worldwide, 2020)[13]

[12] Training health care providers at public hospitals is only one piece of the equation. RHS will also spearhead a public education campaign through local media, churches, and women's groups to ensure women know they have the right to an abortion to safeguard their health and wellbeing.

[13] Police officers cannot make unilateral or arbitrary policy decisions. They must ensure that the constitutional standard on public participation is being held during the development amendment and withdrawal of public policies and they actions must always bring those policies in line with the Constitution.

Section C - Summary of Key legislative and policy publications concerning safe abortion in response to COVID-19 pandemic within the Kenyan context

28. The lack of clear guidelines and policy frameworks to tackle unsafe abortion is a major challenge especially during this time of an unprecedented pandemic (Federation of Women Lawyers, 2019)[14]. Also of serious concern are the lack of adequate precautions against COVID-19 infection for frontline health providers. The first medical staff casualty to the coronavirus in Kenya was a gynaecologist. Civil Society Organisations and other stakeholders have been working in solidarity to advocate for comprehensive SRH including safe abortion options and for the welfare of health care providers. Conversations have been taking place and are still ongoing to draw lessons learnt from COVID-19 to advance ways in which various stake-holders are responding on SRH matters.
29. In December 2020, the 4th Annual Scientific conference on youth and adolescent SRH was held under the theme addressing the three Zeros of the ICP25 by prioritising Adolescent and young people's SRH amidst the pandemic.
30. The 45th KOGS (Kenya Obstetrical and Gynaecological Society) Annual Scientific Congress scheduled for 2021 also sets out to address the theme "Addressing Reproductive Health Barriers and Closing the Gaps in The Wake of Covid-19 Pandemic and Beyond."
31. Meanwhile the Ministry of Health has issued directives, protocols and guidelines, such as screening all patients at entry points before they enter facilities, to curb virus spread while accessing SRH services. The Ministry has also conducted sensitisation and training for service providers on how to handle suspected COVID-19 cases who may present to their facilities. In addition, it has provided reproductive health facilities in the respective counties with hotlines for reporting suspected cases and a directory of quarantine facilities in each county. (International Planned Parenthood Federation, 2020)
32. The Ministry of Health has provided a guideline to offer practical consideration of both preventive and clinical aspects of safe continuity of quality Reproductive, Maternal, Newborn and Family planning services during the COVID-19 Pandemic in Kenya. This guide borrows from various international recommendations; including the World Health Organisation, preceding country COVID-19 response guidelines by MOH, as well as from experience of other countries such as China, Europe and America that have struggled with the evolving impact of the outbreak a little earlier and in a more severe form than is presently being witnessed here in Kenya. As experience and knowledge on COVID-19 is rapidly evolving, it is expected that these interim guidelines will be updated periodically as significant new information becomes available (MOH, April, 2020)[15].
33. Family planning remains an essential service and continuity of care remains a key focus. To guard the safety of clients and providers while relieving pressure on health facilities during the COVID-19 pandemic, rational use of contraceptive methods to deliberately prevent infection or transmission of COVID-19 has been encouraged. Elective surgical

[14] Government officials will be held responsible for their direct actions or inaction as well as for the harm and damage that their acts or omissions cause to survivors of reproductive rights violations.
[15]The COVID-19 pandemic has caused a very high demand for sexual health services and the government of Kenya struggles to keep up with that as well as the COVID-19 cases surge.

contraception is suspended and where applicable, removal of long-acting methods deferred. Due to the high risk of perpetuating community transmission of COVID-19 infection, community-based distribution of contraceptives is restricted to condoms and oral pills. For the same reason, community family planning outreach services are suspended. Care for gender-based violence survivors remain a priority and an essential service.

34. The table below summarises key publications that have been reviewed as a point of reference concerning radical abortion care during this ongoing Pandemic.

Publication, year	Author	Key Highlight
Maternal Newborn Child Health Act, 2017	Makueni County, Kenya	Section 6 of the Act allows for termination under a wide array of circumstances including rape, fetal abnormality as well as mental incapacity to appreciate the pregnancy. Section 7 of the Makueni law recognises further that the statement of a woman who has been sexually assaulted is sufficient proof of the allegation.
Ministry of Health National Guidelines (3rd Edition) on Management of Sexual Violence, 2014	MoH, Kenya.	Page 78 of the Guidelines recognises that one of the rights that a survivor of sexual violence has, is the right to termination of pregnancy and post abortion care.
Ministry of Health Directive on Post- Abortion care, 2013	Directors of Medical Services, Public Health and Sanitation	PAC services are to date administered free of charge in all public facilities.
Practical Guide for Continuity of Reproductive, Maternal, Newborn and Family Planning Care and Services in the Background of COVID-19 Pandemic in Kenya, 2020	Ministry of Health	Postpartum and post abortion family planning counselling coupled with availability of contraceptive methods will continue to be offered through respective health facilities before client is discharged. (MOH, April, 2020)
The Nairobi Summit Statement, 2019	ICPD+25	-Zero unmet need for family planning information and services. Zero preventable maternal deaths and maternal morbidities, integrating a comprehensive package of sexual and reproductive health interventions, including access to safe abortion to the full extent of the law, measures for preventing and avoiding unsafe abortions, - Access for all adolescents and youth, especially girls, to comprehensive and age-responsive information to adequately protect themselves from unintended pregnancies, all forms of sexual and gender-based violence and harmful practices.

Section D - Documented cases of radical abortion related to the existing restrictive laws and regulations

36. Despite what appears to be a straightforward legal position that the High Court ruling on the JMM case provides, studies show that one fifth of women in Kenya do not know abortion is legal. This lack of information highlights the first barrier to access to safe abortion services in the country.
37. It is reported that 41 percent of unintended pregnancies in Kenya will end in an abortion, resulting in approximately 500,000 abortions each year. As a result, maternal mortality is high with about 6,000 deaths per year, 17 percent of which are due to complications stemming from unsafe abortion practices. These statistics are primarily ascribed to a lack of information on access to safe abortion and post-abortion care as women are not aware of what options may be available to them or the health complications they may be facing should they opt for back-alley abortions. (Privacy International's Global Research, 2020)[16].
38. The secrecy associated with abortions in the country perpetuate the idea that abortion care is an illegal and illicit "back door" activity which often leads to unsafe abortions. This is a direct consequence of health providers not receiving training on how to administer safe abortion care and not knowing whether or not they can legally do so, thereby creating a barrier of access to abortion care services. Though the withdrawal of the guidelines and the memo were successfully challenged in court, the Ministry of Health is yet to fully comply with the ruling. It has also been reported that despite the ruling many Kenyans, including health, practitioners continue to be ignorant about the contents of the Guidelines. (Privacy International's Global Research, 2020)
39. Socio-economic factors also play a role in the exercise of sexual and reproductive rights. Safe abortion care in clinics is said to cost about 20,000 Kenyan shillings, whereas unsafe abortions are roughly a tenth of that price. It is clear that women from poorer communities will therefore suffer as they cannot afford to pay for a safe abortion and will have no choice but to resort to back-door abortions. The African Population and Health Research Center calculated that in 2012 the Kenyan government spent an estimated US $5.1 million treating women who had developed complications from unsafe abortion in public health facilities, a number that increased to about $6.3 million in 2016. It would probably cost less for the Kenyan government to provide affordable abortion services than it does to treat the complications borne by unsafe abortions in the country. (Privacy International's Global Research, 2020)
40. Reorganisation of the public health system at county and national levels in response to COVID-19 requires adequate resourcing to meet sexual and reproductive healthcare needs of women and girls. Unfortunately, in 2018, the United States cut aid to foreign family planning programs which left many women in Kenya without affordable access to contraceptives leading to many resorting to back-door and unsafe abortions. This foreign policy change acted as a blanket ban for the use of foreign aid funds for abortion care under any circumstances and affected notable providers of sexual and reproductive health services in Kenya. (Privacy International's Global Research, 2020)[17].

[16] Although legalising abortion alone may not reduce the incidence of abortion, it reduces women's resort to unsafe terminations and delays in seeking care and increases service provider willingness to provide care.
[17] Access to family planning and reproductive health (FP/RH) services is critical to the health of women and children worldwide. Improving access to FP/RH services globally can help prevent maternal deaths and reduce unintended pregnancies. Each year, approximately 303,000 women die from complications during

41. In addition, the Trump administration restored the Mexico City Policy or 'Global Gag rule' which required all non-governmental organisations' operating abroad to cease the provision of pregnancy by choice initiatives or risk being denied federal funding. The policy which was intended to reduce the number of abortions instead had the opposite effect. Lack of funding due to the above policies has closed clinics and curtailed family planning and maternal child healthcare services thereby frustrating the affordable access to safe abortion care services. (Privacy International's Global Research, 2020)
42. Another barrier to safe abortion care is the stigma which is partly fuelled by gender stereotypes. Societal attitudes towards women who access abortion care remain largely negative and studies show that psychosocial and cultural barriers are to blame for women not seeking abortion care from healthcare facilities. The fear of stigmatisation founded on negative religious and cultural beliefs held constitutes a major barrier to the access of safe and legal abortion care. (Privacy International's Global Research, 2020)

pregnancy and childbirth, almost all in developing countries. It is also estimated that approximately one-third of maternal deaths could be prevented annually if women who did not wish to become pregnant had access to and used effective contraception.

Section E - Existing evidence from Kenyan grassroots organisations

43. The only national estimate of abortion in Kenya is based on a study of women who were treated in public hospitals for abortion related complications over a three-month period in 2002. According to that study, more than 300,000 abortions occur in Kenya annually, or 46 per 1,000 women of reproductive age. The study, however, did not differentiate between induced abortions and miscarriages, and the true incidence of induced abortion is yet unknown. Because abortion is highly restricted and stigmatised in Kenya, measuring abortion levels is challenging, and underreporting is common. A 2009–2010 study conducted in four poor urban settlements in Nairobi asked women about pregnancy and pregnancy loss. Of the 200 women who had experienced a pregnancy loss, fewer than 4% characterised it as a voluntary termination, and the vast majority (80%) reported that they had had a miscarriage. (Guttmacher Institute, 2012)

44. A situational analysis conducted in a rural pastoralist community had some noteworthy findings, since the beginning of COVID-19, routine maternal services in Kajiado County have come under threat because of competing tasks in the health facilities where more energy has been focused on COVID-19. Some of the effects on delivery SRH include: reduced access to family planning services; increased sexual and gender based violence; increased child marriages; increased teenage pregnancies; female genital mutilation and other harmful cultural practices; higher risk of increase of maternal and perinatal mortality due to reduced access to SRH services caused by restriction of movement due to current lockdown or curfews imposed by the government and fear of contracting the virus; and increased maternal mortality due to home deliveries caused by curfews. There has been a reduction in the use of family planning services among adolescents. The 15–19 age bracket appears to be having difficulty in accessing family planning compared to the 20–24 age group. This correlates with increased teenage and adolescent pregnancy, which went up from 29% in 2018 to 34% in 2019, although early indications are that the 2020 figure will be lower, perhaps because of higher access to services during the pandemic. (Likalamu, 2020)

45. As previous noted the costs of safe abortion services are too high for many girls and women seeking those services. After the withdrawal of the 2012 standards and guidelines for reducing morbidity and mortality related to unsafe abortion in Kenya, only private health facilities offer safe abortion services, albeit in secret for fear of victimisation and harassment. This has made access to safe abortion too expensive and out of reach for most girls and women in need of the services.. This exposes Kenyans to unsafe services black-market which are mostly conducted through self-prescription or in the hands of unqualified and ill-equipped individuals. (Federation of Women Lawyers, 2019)[18]

46. Comprehensive national data on the impact of COVID-19 on teen pregnancy rates are not yet available. At least anecdotally, though, some healthcare providers suspect a coronavirus effect. Increased barriers to accessing safe services: due to quarantines, self-isolation rules, school closures which impact caring responsibilities, travel bans, borders closing, and reduction in-availability of public services, it has become more

[18] We calculated that in 2012 the Kenyan government would have spent an estimated US $5.1 million treating women who had developed complications from unsafe abortions. We estimated that by 2016 this figure would have gone up to US $5.2 million. This is roughly what the Kenyan government spends funding free primary health care for six months of the year.

difficult for both providers and clients to travel to deliver or receive safe abortion and contraceptive care, impacting people's SRH in particular. With school closures, Comprehensive Sexuality Education programs that assist adolescents in understanding and accessing SRH care and rights have also been curtailed. Furthermore, economic insecurity for many, in particular those already living in vulnerable situations, is increasing as a result of the pandemic, leading to greater difficulty in paying for care.

47. National lockdowns have also led to disruptions to reproductive supply chains, leading to an increasing shortage of abortion medications and contraceptives and further limiting individuals' ability to access abortion and contraceptive care that suits their needs and preferences. A shortage of health care providers and increased waiting times for procedures considered to be non-emergency care, are also making it harder for individuals to access care, particularly in public facilities. In tandem, emergency reproductive and maternal health services are affected by over-stretched facilities and staff. There is a remaining risk of diversion of funds from critical SRH programs due to competing government and donor priorities.

Section F - Emerging extra-legal interventions that enhanced access to safe abortion services and information

48. The Kenyan healthcare system has now shifted focus to COVID-19 response, a move that is likely to jeopardise access to SRH services which are not deemed a priority in the face of the COVID-19 crisis. Requirements of social distancing, consistent wearing of masks and regular sanitising has limited the number of face-to-face consultations and physical public sensitisation activities. However, it has led to increase in use of tele-counselling and use of social media including Twitter, Facebook and WhatsApp to share information, conduct online comprehensive sexuality education (CSE) by trained CSE facilitators to young people, and referrals to designated accessible health facilities for SRH services through SMS text interventions.
49. During the period of the first 6 months of the locked down through implementing a virtual training, the MAMA network supported the launch of 6 hotlines including here in Kenya. These hotlines in their first days of implementation recorded a minimum of 5 calls a week with the highest number being 22 calls. Despite access to limited resources hotlines through peer-to-peer learning mentorship from more established hotlines have adopted new and improved marketing strategies while constantly updating their posters, IEC material and interactive posts and campaigns on social media (Ebankali, December, 2020).
50. This pandemic has also created new opportunities for online counselling, referral and information platforms such as Safe2Choose to leverage the power of the digital revolution and the increased in the local smartphone market penetration and access to cable and wireless internet. As and when needed Safe2choose refers women to trusted, trained and pro-choice healthcare providers close to their location for safe and empathetic abortion care. In 2020 Safe2Choose also opened a TikTok account and a YouTube channel and has collaborated with influencers to target younger audiences with relatable content. In the same year (2020) it counselled 441 and referred 382 Kenyans (Diaz, December,2020).
51. Technology has significantly evolved and changed trends in the health sector. Patients are now able to secure appointments and receive medical appointments online. The Kenyan Health Act 2017 defines tele-medicine as the provision of healthcare services and sharing of medical knowledge over distance using telecommunications, including consultative, diagnostic and treatment services. In the wake of COVID, the sexual and reproductive health arena has equally seen creative evolutions in access to safe abortion with organisations advancing the use of misoprostol through online platforms. This route has been lauded as encouraging access to otherwise highly restrictive services. This form has farther been appreciated as discreet and thus protecting the true identity of the woman/girl and maintaining her privacy. Legal and ethical issues surrounding access to misoprostol via online websites are yet to be critically nuanced in Kenya. Online dispensation of abortion-related drugs is premised on the presumption that the pregnancy's gestational period has been ascertained. In the wake of teenage pregnancies, irregular period cycles and sexual violence where young girls and survivors respectively are often unsure of the exact date of last period, online platforms run the risk of prescribing an overdose of misoprostol to an unsuspecting client who maybe more eager to have the pregnancy terminated than ascertain the gestational period. Additionally, not all existing online platforms are linked to physical facilities where patients can be referred to should complications arise. As a result of such gaps patients with adverse reactions to misoprostol risk over bleeding in the silence of their homes for fear of prosecution, stigmatisation or victimisation if they present themselves

at facilities that are not sensitive to abortion issues legally the use of the online platforms not only presents a probable cause for worry due to the above complications but also the risks of lawsuits for medical malpractice (Saayo, Leteipan, & Sibande, December, 2020)[19].

52. It's important to note due to the social inequality digital divide between urban and rural youth, avenues for offering SRH services and commodities to AGYW have been increased, for instance, through the use of Community Health Volunteers in remote regions and/or informal settlements where internet isn't available. Through homebased approach using community key resource persons marginalised youth such as adolescent and young women with disability have had increased and sustained access to basic SRH products such as condoms and oral pills and safe abortion information and knowledge (Mirzoyants, Thuku, Kapi, Namalenya, & Antillon, December, 2020).

Section G – Conclusions

53. To conclude, the report has identified pre-COVID-19 context and challenges faced during the pandemic regarding SRH. On abortion, these include:

Pre-COVID-19

- Lack of public knowledge on the legal status on abortion
- Lack of health professional knowledge on the legal status on abortion
- Prohibitive costs in accessing safe abortion
- Abortion stigma
- Restricted or removal of funding from international donors

During COVID-19

- Curtailment of SRH services
- Curtailment of Comprehensive Sexuality Education programs
- Disruptions to reproductive supply chains, leading to an increasing shortage of abortion medications and contraceptives limiting individuals' ability to access abortion and contraceptive care that suits their needs and preferences.
- A shortage of health care providers
- Increased waiting times for procedures

Positive developments during COVID-19

- Increase in use of technology to raise awareness of tele-medicine, however this is limited to those with access to IT

54. In the next phase of the project the research team seek to explore the direct experience of stakeholder groups such as activists, abortion providers and pharmacists on the impact of COVID-19 on access to abortion.

[19] But for those women who cannot get the vet drugs, prefer to use ulcers tablets. The most common being Cytotec and Misoprostol that can be easily bought over the counter for Sh90 per tablet at various city pharmacies. Only three tablets are needed to procure an abortion.
Mioprostol is not used orally but inserted into the private parts to avoid deadly side effects.
"The drug has very unpleasant side effects, including nausea and vomiting. So, to reduce side effects, they insert it to be absorbed into the bloodstream,"

55. For further information on the project contact Dr Fiona Bloomer, Ulster University, fk.bloomer@ulster.ac.uk.

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